Witness Name: HHJ Thomas Teague KC
Statement No.: 1
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF HHJ Thomas Teague KC, Chief Coroner of England and Wales

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I, HHJ Thomas Teague KC, Chief Coroner of England and Wales, will say as follows: -

1. I have been Chief Coroner since my appointment took effect on 24 December 2020. I succeeded HHJ Mark Lucraft KC (The Recorder of London), who was Chief Coroner from 1 October 2016 to 23 December 2020. I confirm that I have consulted HHJ Lucraft KC on the contents of this witness statement.

2. The Chief Coroner is an independent judge whose role is to fulfil the specific statutory functions set out in the Coroners and Justice Act 2009 (the 2009 Act) and provide overall judicial leadership of the coroner service. The primary responsibilities include: providing support, leadership, and guidance for around 500 coroners throughout England and Wales; representing the interests of coroners to Ministers and Parliament; working with Judicial College to provide coroner training; consenting to coroner appointments; providing an annual report to the Lord Chancellor; and sitting in the High Court on coronial cases.

3. Coroners are independent judicial office holders with responsibility for their own investigations and inquests. It is the individual coroner who makes decisions about such matters as the scope of an inquiry and evidence to be gathered for and adduced in an inquest. Some inquests are conducted by a coroner alone, and some by a coroner sitting with a jury. The Chief Coroner has no power over coroners'

individual decisions, or over the operational arrangements made to fund and resource the coroner service. The Chief Coroner also has no power when it comes to discipline; as with other judges, complaints about the misconduct of coroners are dealt with by the Judicial Conduct Investigations Office. The power that the Chief Coroner wields most often is a form of 'soft' power, relying on the exertion of influence through persuasion, advice and encouragement.

The role of coroners and the coroner service

4. The coroner service in England and Wales is a small but vitally important part of the justice system. Its primary purpose is to investigate violent or unnatural deaths, deaths of which the cause is unknown and deaths that have occurred in custody or otherwise in state detention.

5. A coronial death investigation is a form of summary justice designed to provide answers to four statutory questions, namely who the deceased was and when, where and how (usually confined to meaning 'by what means') the deceased came by his or her death. Where the enhanced duty of investigation arises under Article 2 of the European Convention on Human Rights, the coroner or jury must examine the wider circumstances in which the death occurred, but still cannot express an opinion on any topic other than the four statutory matters to be ascertained. The attribution of blame forms no part of the coroner's role. The 2009 Act expressly prevents inquest determinations from being framed in such a way as to appear to determine any question of civil liability or any question of criminal liability on the part of a named person.

6. Coroners exercise a fact-finding 'inquisitorial' jurisdiction. Unlike most courts and tribunals in England and Wales, which have an adversarial system in which the participants resolve a pre-existing dispute in the arena provided by the court, the coroner's court acts on its own motion to investigate an individual death within the boundaries set by statute. As Lord Lane said in *R v South London Coroner Ex p. Thompson (1982) 126 S.J. 625*:

"It should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use."

7. The death investigations conducted by coroners fulfil many important functions, including:

   - providing bereaved families with answers as to how their loved ones died with the assurance that an independent judicial process has investigated any relevant concerns;
   - contributing to the accurate registration of deaths, thereby enabling more secure analysis of trends in public health;
   - fulfilling any responsibilities relating to a death that the state may have in accordance with Article 2 of the European Convention on Human Rights; and
   - considering whether any circumstances revealed by an investigation give rise to a risk of future deaths and alerting those who might be able to mitigate or eliminate such risks. These reports made by coroners are often referred to as Prevention of Future Deaths Reports.

8. The coroner service is made up of independent coroner areas, of which there are currently 77. Each coroner area has a senior coroner and a number of fee-paid assistant coroners. In many coroner areas, there will also be at least one area coroner.

9. The senior coroner is the senior salaried leadership judge within a coroner area and fulfils significant judicial and administrative responsibilities. The senior coroner will typically:

- undertake a wide range of casework, including conducting the most complex inquests;
- manage the area's caseload, judicial listing and the on-call rota;
- work collaboratively with the local authority that funds their area and with the local police force (if it provides coroner's officers for the service, which many do) to manage the operational aspects of the service including accommodation, staffing, and resourcing;
- organise and support the local coroner team;
- manage the area's relationships with local stakeholders, the public and bereaved people; and
- prepare for mass fatality disasters.

10. An area coroner is a salaried judge who undertakes casework and supports the senior coroner to manage the coroner area. Since the role came into existence in 2013, there have been growing numbers of area coroners. It is my policy to encourage their appointment to provide stronger support for senior coroners and improve the efficiency and resilience of the service.

11. Assistant coroners are fee-paid judges who typically work part-time as coroners and part-time within the legal profession. As a result, they work on investigations and conduct inquests, but generally do not assist with the management of a coroner area.

12. Coroners have an important function as part of the system of local preparedness for mass fatalities and other serious events leading to loss of life. This role flows directly from the coroner's statutory duties. In the event of a mass fatality incident, the coroner will be responsible for leading the independent judicial investigation into each death. They will have legal control of the bodies and will need, with the assistance of local authority and other local partners, to make mortuary space available to facilitate their investigation. This role in local preparedness for deaths of violent, unnatural and unknown cause inevitably overlaps with wider preparedness for large-scale deaths of natural cause.

Reporting COVID-19 deaths to coroners

13. A coroner becomes involved in considering a person's death when the coroner is notified that there is a body of a deceased person in their coroner area.

14. Anyone can notify a coroner of a death, so coroners will sometimes be notified by bereaved families, members of the public and the police. However, there is a statutory obligation on some individuals and bodies to notify coroners of deaths, including:

    a) registered medical practitioners who come to know of a death to which certain circumstances apply; and
    b) registrars when they are informed of a death and particular circumstances apply.

15. The Notification of Deaths Regulations 2019 (NODR Regulations) require a registered medical practitioner to notify a coroner where the registered medical practitioner suspects that:

    a) the death was due to one of the 9 causes listed in regulation 3(a), which include 'the use of a medicinal product, controlled drug or psychoactive substance', 'the person undergoing a treatment or procedure of a medical or similar nature', or 'an injury or disease attributable to any employment held by the person during the person's lifetime';
    b) the death was unnatural, even though it does not fall within any of the circumstances listed in regulation 3(a);
    c) the cause of death is unknown; or
    d) the death occurred in custody or otherwise in state detention.

16. The guidance to the NODR Regulations states: 'A death is typically considered to be unnatural if it has not resulted entirely from a naturally occurring disease process running its natural course, where nothing else is implicated.'

17. The NODR Regulations also require a notification to the coroner where:

a) there is no registered medical practitioner who can meet the legal requirements to certify the death (or if there is, there is no-one who can certify within a reasonable time); or
b) the identity of the deceased person is unknown.

18. Similar notification provisions apply to registrars. Regulation 41 of the Registration of Births and Deaths Regulations 1987 requires the registrar to notify a coroner where:
    a) there is no medical certificate of cause of death (MCCD), or the MCCD is not acceptable for registration purposes;
    b) the cause of death is unknown;
    c) the registrar has reason to believe the death was unnatural, or that it was caused by violence or neglect or by abortion, or there are suspicious circumstances;
    d) it appears to the registrar that the death occurred during an operation or before recovery from the effect of an anaesthetic; or
    e) it appears to the registrar that the death was due to industrial disease or industrial poisoning.

19. Although COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010, those regulations do not require a referral to be made to a coroner. A death will only be referred to a coroner if it falls within the notification obligations set out elsewhere in legislation, or if someone is concerned about the death and chooses to contact a coroner (for example, the coroner may be notified by the deceased person's family).

The duty to investigate

20. Once a coroner has been notified of a death, a judicial decision must be made as to whether the duty under section 1 of the 2009 Act is engaged. Coroners have no jurisdiction to investigate a death that falls outside that provision.

21. Section 1 of the 2009 Act provides that coroners must investigate deaths that are reported to them if the deceased's body is within the coroner's area and the coroner has reason to suspect that:

a) the deceased died a violent or unnatural death,
b) the cause of death is unknown, or
c) the deceased died while in custody or otherwise in state detention.

22. This means that coroners are not under a duty to investigate natural deaths that occur in hospitals or in the community.

23. It is clear from section 1 of the 2009 Act that to trigger the duty to investigate it is necessary for the deceased person's body to be within the coroner's area when the death is reported. There is one exception to this requirement, as section 1(4) of the 2009 Act allows a coroner to investigate a death if directed to do so by the Chief Coroner where the coroner has reason to believe that:

a) a death has occurred in or near their coroner area;
b) the circumstances of the death are such that there should be an investigation into it; and
c) the coroner would not otherwise have jurisdiction because of the destruction, loss or absence of the body.

24. This provision enables a coronial investigation to take place where, for example, a person has gone missing and the evidence suggests suicide or homicide, or where someone has drowned but their body cannot be found, or where a person's manner of death has been so destructive that their body cannot be recovered. It is also commonly used where a death at first appears natural and the body is cremated without a report to the coroner, but evidence later comes to light that suggests an investigation is needed.

25. On 24 March 2020, the World Health Organisation published a paper on the origins of COVID-19, which stated: 'all available evidence suggests that SARS-CoV-2 has a natural animal origin and is not a manipulated or constructed virus'. As COVID-19 is a naturally occurring illness, if a person who was not in custody or other state detention is known to have died of COVID-19, and there are no unnatural factors

involved, the person's death will have been natural and there will be no need for a coroner's investigation.

26. Between 1 March 2020 and 28 June 2022, some COVID-19 deaths were reported to coroners because the person's cause of death was unknown, or because the person had died in custody or other state detention. Some were reported because there were unnatural factors that may have caused or contributed to the person's death, for example where it was suspected that:

    a) the medical treatment received by the deceased was unduly delayed or was inappropriate;
    b) the deceased had died because of a COVID-19 vaccine; or
    c) the deceased had contracted COVID-19 at work and the employer had not taken appropriate steps to protect its employees from contracting the disease.

27. Some COVID-19 deaths were reported to coroners even though they were natural deaths that did not occur in custody or other state detention because there was no registered practitioner who could certify the death.

28. Not all COVID-19 deaths reported to a coroner led to an investigation. My predecessor reminded coroners in his Guidance Note 34 that it was appropriate for deaths from COVID-19 that did not in law require referral to the coroner to be dealt with via the MCCD process. Where no MCCD had been signed, he suggested that coroners could discuss this with the relevant doctor and make them aware of facts that might be relevant to the decision to sign an MCCD. If an MCCD was signed and the coroner was satisfied that there was no duty to investigate the death, the coroner could issue a form 100A (which confirms to the registrar that the coroner does not need to investigate) and the death could be registered.

29. If the coroner was not sure that the duty to investigate under section 1 of the 2009 Act was engaged, the coroner could request a post-mortem examination. If the post-mortem examination produced a natural cause of death, the coroner could use a form 100B to confirm there was no need to investigate, enabling the death to be registered.

30. If the coroner decided that their duty under section 1 of the 2009 Act was engaged, they would commence an investigation. One of the following would then happen:

    a) If a post-mortem examination revealed a natural cause of death and the coroner decided that continuing the investigation was unnecessary, the investigation would be discontinued under section 4 of the 2009 Act.
    b) If there were criminal proceedings, the investigation might end without being resumed.
    c) There would be an inquest.

31. The Chief Coroner does not collect statistics on how many inquests take place each year. The Ministry of Justice publishes coroner statistics annually in May. These are not broken down according to causes of death, so it is not possible to tell from any published statistics which inquests related to COVID-19.

COVID-19 as a cause of death

32. On 1 April 2020, the General Register Office issued an e-alert to registrars which said:

    'Further to previous advice registration officers should now be aware that –

    - *Covid-19 is an acceptable, direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death (MCCD)…..*

    For clarity, the recording of "Probable Covid-19" or "Possible Covid-19" as the cause of death is not acceptable on its own. However, when accompanied by an acceptable cause of death in part 1 of the MCCD it can be accepted for registration without need for referral. If the doctor has used such a term, without the support of another acceptable cause of death then, during the emergency period, rather than immediately reporting to the coroner registrars should firstly try to seek a fresh MCCD from the doctor. Further advice should be sought from GRO in respect of any issues or difficulties relating to this issue…'

33. The reference to a 'cause of death' within the e-alert is to the medical cause as recorded by a medical practitioner in an MCCD.

34. While my predecessor drew the attention of coroners to the General Register Office's publication by email dated 1 April 2020 (the email is exhibited to this statement as CC/03 – [INQ000477336] and is also referenced in paragraph 43 below), the publication itself was addressed to registrars, not coroners. It does not constitute guidance issued by the Chief Coroner, who forwarded it to coroners for information purposes only.

35. In Guidance Note 34, issued on 26 March 2020, my predecessor expressed support for the position communicated by NHS England and the Chief Medical Officer to medical practitioners in England that Covid-19:

    a) is an acceptable direct or underlying cause of death for the purposes of completing the MCCD, and
    b) as a cause of death (or contributory cause) is not a reason on its own to refer a death to a coroner under the 2009 Act.

External engagement in response to the COVID-19 pandemic

36. Between 1 March 2020 and 28 June 2022, the Chief Coroner engaged with the following bodies in relation to the COVID-19 pandemic as set out below:

<u>Department of Health and Social Care (DHSC)</u>

37. My predecessor and the Chief Coroner's Office engaged with officials in DHSC in relation to the impact of the pandemic on the coroner service and the implementation of easements to death registration requirements. The following provisions in the Coronavirus Bill - which became the Coronavirus Act 2020 (CA 2020) and took effect on 25 March 2020 - impacted on coroners and were discussed by DHSC and the Chief Coroner as the Bill was being developed:

    a) Enabling any registered medical practitioner to issue a medical certificate of cause of death (MCCD) without having attended the deceased, provided they were sufficiently able to ascertain the cause of death.

b) Extending from 14 to 28 days the period within which an attending medical practitioner had to have seen the deceased prior to death for an MCCD to be accepted by the registrar without referral to a coroner.
c) Removing the requirement for a death to be reported to a coroner when the medical practitioner who had issued the MCCD had not attended the deceased, but another medical practitioner had seen the deceased within 28 days prior to death or had seen the body after death.
d) Ensuring that there was no mandatory requirement for a jury in inquests into deaths which were suspected to have been caused by COVID-19.

38. The Chief Coroner's guidance to coroners on the CA 2020, which explains in more detail the changes made by the Act, is exhibited to this statement as CC/01 – [INQ000477305].

39. Although as a judge the Chief Coroner could not comment on policy (for example in relation to the sufficiency of the scrutiny that would result from the changes) my predecessor and the Chief Coroner's Office were able to explain the impacts of the pandemic on the coroner service and how the easements would help the service to function in the context of a substantial increase in deaths, and changes to how doctors cared for patients. Without the easements, many more natural deaths would have been referred to coroners because the legal requirements for them to be certified by doctors and/or registered without a coroner referral would not have been met.

40. The provision in the CA 2020 relating to inquest juries was included after a statutory instrument was laid designating COVID-19 as a notifiable disease under the Health Protection (Notification) Regulations 2010. One impact of that designation was that when there was going to be an inquest and the coroner had reason to suspect that COVID-19 was the cause of death, that inquest had to be held with a jury. My predecessor was concerned that the Government might not have appreciated the impact on the coroner service. Because jury cases tend to be complex, cannot be conducted remotely and, at the time, required extremely large court spaces to allow for the requirements of social distancing then in place, increasing the number of such cases within the coroner system would have increased backlogs at a time when the

service was already under immense pressure. Having listened to the Chief Coroner's concerns, the Government inserted wording into section 7 of the 2009 Act preventing a jury from being mandatory where the coroner had reason to suspect a death was caused by COVID-19. In accordance with section 7(3) of the 2009 Act coroners could still, however, decide to hold a jury inquest into a COVID-19 death if the coroner thought there was sufficient reason for doing so.

41. In April 2020, DHSC officials spoke to my predecessor about DHSC's proposal to ensure scrutiny by medical examiners of the deaths of health and social care staff who had died with COVID-19. The Health Service and Social Care Workers (Scrutiny of Coronavirus-related Deaths) Directions 2020, which directed NHS trusts and NHS foundation trusts in England to use medical examiners to conduct such scrutiny, were published on 2 July 2020. Those directions led to the referral to coroners of deaths that had originally been considered to be natural, allowing the coroner to decide whether or not an inquest was required. As a result of this scrutiny, my predecessor and I received requests from coroners under section 1(4) of the 2009 Act (which are requests for a direction by the Chief Coroner to enable a coroner to conduct an investigation without a body) in cases where a deceased health or social care worker's body had already been cremated, but the coroner considered an investigation was needed.

42. On 11 July 2020 and 21 July 2020, my predecessor and the Chief Coroner's Office took part with the DHSC in Ministerial Board on Deaths in Custody sub-meetings which considered lessons learned from the emergency response in custodial settings (including prisons, mental health inpatient accommodation and immigration asylum centres) and steps that could be taken to preserve life as the pandemic developed. Aware from those contacts that the infection rate among those in state detention was particularly high, my predecessor was able to update coroners as to conditions in custodial settings, where social distancing was often impossible. That advice helped coroners to plan for a potential increase in jury inquests pursuant to section 7(2) of the 2009 Act (which makes a jury inquest mandatory for deaths in custody or other state detention where it is suspected that the cause of death was violent or unnatural, or the cause of death is unknown).

Public Health England (now the UK Health Security Agency) and Public Health Wales

43. In early March 2020, my predecessor and the Chief Coroner's office engaged with Public Health England (PHE) about PHE issuing guidance on the infection risk posed by handling bodies of deceased persons known or suspected to be infected with COVID-19, and about the Chief Coroner issuing guidance on the practical implications for coroners of dealing with excess deaths. The Chief Coroner and PHE provided comments on each other's draft guidance to help ensure all relevant issues were covered and the guidance aligned. The Chief Coroner's finalised guidance was published on 26 March 2020 and is exhibited to this statement as CC/02 – [INQ000477335]. It explained how coroners should be involved in planning for excess deaths, the practical steps they could take to improve resilience and capacity, how referrals of natural deaths could be managed, and matters to consider in relation to wider death management (including information provided by PHE on infection control within the death management system). The finalised PHE guidance was published by PHE and circulated by the Chief Coroner's Office to all coroners on 1 April 2020 (the email is exhibited to this statement as CC/03 – INQ000477336).

44. My predecessor and the Chief Coroner's Office engaged with PHE about COVID-19 being designated as notifiable under the Health Protection (Notification) Regulations 2010, (meaning that any death resulting from the disease had to be notified to PHE). As was clear from the Notification of Death Regulations 2013 and section 1 of the 2009 Act, this had no bearing on whether deaths suspected to have been from COVID-19 were reportable to coroners, or on whether there was a duty to conduct a coronial investigation. The Chief Coroner made this clear in guidance (the first email setting this out is exhibited to this statement as CC/04 – [INQ000477337]).

45. In April 2020, the Chief Coroner's Office discussed with PHE a proposal to fast-track the establishment of a National Real Time Suicide Surveillance System in response to growing concerns that there might be an increase in COVID-19 related suicides. Because the project was too complex to be introduced quickly, and would have placed an additional burden on coroners whilst they were under severe pressure because of the pandemic, it was not progressed at that time.

46. In May 2020, PHE engaged with my predecessor regarding post-mortem testing for COVID-19 and how the coroner's jurisdiction might affect any scheme. A pilot surveillance programme was developed, which was run with a small number of funeral directors. One of the eligibility criteria was that the deceased individuals tested would not be under the jurisdiction of the coroner. Shortly after PHE became the UK Health Security Agency (UKHSA) on 1 October 2021, UKHSA raised some queries about the scheme with the Chief Coroner's Office. For example, they were unsure how to proceed in relation to testing where a sample had been taken from a deceased person's body in accordance with the scheme, but that person's death had then been reported to a coroner (meaning the coroner had legal control over the body). The Chief Coroner's Office was able to help UKHSA with its queries.

47. Towards the end of 2021, my office and I engaged with UKHSA about a proposal to set up an ad hoc programme under which coroners could allow post-mortem upper respiratory tract swabs to be tested by UKHSA for a range of respiratory viruses. This pilot was proposed because UKHSA thought that as polymerase chain reaction (PCR) testing in the community decreased, post-mortem testing could help to understand the epidemiology of COVID-19. The funeral director pilot was considered by UKHSA to have been reasonably successful, but issues surrounding Human Tissues Authority licences meant that scaling-up the programme was not feasible. UKHSA therefore wanted to explore an alternative surveillance method that involved working with coroner cases. The proposal was that coroners and pathologists would, at their discretion, identify cases in which it would be appropriate to submit an upper respiratory tract viral swab, and UKHSA would pay for the tests to be run. Discussions relating to the scheme continued during 2022 and 2023.

48. The Chief Coroner and Chief Coroner's Office had no contact with Public Health Wales.

Chief Medical Officers in England and Wales

49. I understand that there was a brief discussion between officials early in the pandemic about whether engagement was needed between my predecessor and the Chief Medical Officers about statistics, but this did not lead to a substantive discussion.

Neither my predecessor nor I had any substantive engagement with the Chief Medical Officers relating to the pandemic.

British Medical Association (BMA)

50. On 28 April 2020, my predecessor issued Guidance No. 37 entitled: 'COVID-19 deaths and possible exposure in the workplace'. The guidance explained that although COVID-19 deaths are usually natural and are not reported to coroners, work-related deaths should be reported and may engage the coroner's duty to investigate. The note then provided advice on the issues that are likely to be raised in cases where it is alleged that a COVID-19 death was work-related (for example,. where it is suspected that the deceased person contracted COVID-19 at work). One of these issues was how coroners should deal with allegations about systemic failings, such as the adequacy of personal protective equipment (PPE) provision, when determining the scope of inquests. The guidance included the following wording: *'Coroners are reminded that an inquest is not the right forum for addressing concerns about high-level government or public policy. The higher courts have repeatedly commented that a coroner's inquest is not usually the right forum for such issues of general policy to be resolved…By the same reasoning, an inquest would not be a satisfactory means of deciding whether adequate general policies and arrangements were in place for provision of personal protective equipment (PPE) to healthcare workers in the country or a part of it.'*

51. The BMA objected to this wording, and on 1 June 2020 sent my predecessor a pre-action protocol letter arguing that the guidance did not accurately state the legal position, provided incorrect advice to coroners, and could result in coroners not undertaking adequate investigations into the deaths of healthcare workers where a contributory factor to the deaths may have been the lack of appropriate PPE.

52. My predecessor considered that his guidance appropriately directed coroners' attention to relevant statements by the higher courts and provided coroners with practical advice. He also noted that the guidance repeatedly recognised the need for individual coroners to make their own independent decisions on scope. However, he decided to amend the guidance to ensure that it could not be read as constraining

coroners. There were various changes to the guidance when it was reissued on 1 July 2020, but the wording that was specifically added in relation to PPE read: '*When handling inquests in which questions such as the adequacy of personal protective equipment (PPE) for staff are raised, coroners are reminded that the focus of their investigation should be on the cause(s) and circumstance(s) of the death in question. Coroners are entitled to look into any underlying causes of death, including failures of systems or procedures at any level, but the investigation should remain an inquiry about the particular death*'. The amended guidance is exhibited to this statement as CC/05 – [INQ000477338]). Having considered the amended guidance, the BMA did not issue a claim.

The Office for National Statistics

53. In early March 2020, my predecessor and the Chief Coroner's Office engaged with ONS regarding the handling of COVID-19 deaths by coroners. Although most COVID-19 deaths are natural and are not investigated by coroners, ONS wanted to understand in what circumstances there would be coronial investigations into COVID-19 deaths, to anticipate the potential impact on statistics.

54. On 9 April 2020, the Chief Statistician for the Ministry of Justice wrote to my predecessor regarding discussions he had had with the Deputy National Statistician about accessing early provisional data held by coroners. In order to improve the evidence that ONS were providing to the most senior levels of government, they wanted to be able to access information about people suspected to have died from COVID-19 whose deaths were referred to coroners (which ONS estimated to be about 10% of COVID-19 deaths). The letter is exhibited to this statement as CC/06 – [INQ000477339])

55. My predecessor responded on 14 April 2020, explaining that most deaths reported to coroners do not lead to an inquest (for example in 2018 inquests only took place in 14% of cases), so registration can usually take place within the same sort of timescales as apply to other deaths. Where a death is reported to the coroner, it will not be registered until the conclusion of the inquest, but my predecessor had issued guidance encouraging coroners to hold short inquests within quick timescales where

possible, so as to facilitate rapid death registration. He explained that some COVID-19 death investigations might be complex and contentious, and so take longer to reach a conclusion, but it would be highly inappropriate for a coroner to offer a 'private' view on a cause of death outside the judicial process. He also pointed out that the statistics ONS would be able to produce using the coroner's 'best guess' early on in an investigation would not be accurate, as the inquests might lead to different outcomes from those initially expected. Finally, he noted that producing a report for ONS would place an additional burden on coroner services, which were (and continue to be) chronically under-funded and were at the operational forefront of the justice system's response to COVID-19. His letter is exhibited to this statement as CC/07 – [INQ000477340]).

56. Mr Blunt sought permission for the letters to be shared with ONS, which my predecessor granted.

The impact of the pandemic on the coroner service

57. The pandemic had a significant impact on the functioning of the coroner service, and on the organisations with which the service interacts.

58. On 19 March 2020, my predecessor issued guidance to all coroners about adjourning inquests. He noted that most of a coroner's judicial work is done at an early stage of investigation, with only a small percentage of cases proceeding to inquest. As workload demands were likely to increase significantly, he advised that some inquests would need to be adjourned and decision-making on reports of death prioritised to enable bodies to be released for funeral. The guidance he gave coroners on adjourning inquests (which is exhibited to this statement as CC/08 – [INQ000477341]) was that they should:

    a) adjourn any jury inquests of significant length that were due to start between 31 March and Friday 28 August;
    b) consider adjourning long or complex inquests not involving a jury that were due to start between 31 March and Friday 28 August (including those requiring many witnesses to attend in person);

c) continue any inquest hearings which were ongoing, where possible.
d) proceed with less complex inquests and pre-inquest reviews listed to start between 19 and 31 March.
e) consider the circumstances on a case-by-case basis, try to reduce risks where possible and consider adjourning if necessary, for example where people involved were particularly vulnerable, or were self-isolating.

59. The public health situation evolved quickly, so it was not long before further guidance was needed. On 26 March 2020, my predecessor issued Guidance No. 34 to advise coroners on the impact of the first national lockdown and the rise in excess deaths. His advice included that:

a) No in-person hearings should take place unless they were urgent and essential and would be safe for those involved.
b) If hearings could take place remotely they should do so, but the coroner needed to be in court to fulfil the requirement for hearings to take place in public.
c) Social distancing must be in place throughout court buildings.
d) Coroners should considering prioritising decision-making on reports of death over conducting inquests.
e) Coroners might have to perform less detailed death investigation processes than prior to the pandemic. For example, it might not be feasible to order a post-mortem examination in all cases where they would previously have done so. Coroners remained under their usual statutory duties and had to conduct proper investigations (which might mean adjourning). However, they could exercise their discretion in a pragmatic way that took account of the effects of the pandemic.
f) The pressure on pathologists was a factor coroners should consider in deciding whether to order an examination (or a particular type of examination, for example, a non-invasive one). Complex and sensitive cases might need to be prioritised.
g) Coroners and staff were regarded as performing key public services and were key workers for the purpose of government guidance.
h) Coroners rely on others to gather information and to provide evidence in a death in prison, including HM Prison and Probation Service, the healthcare provider within the prison, the police and the Prisons and Probation Ombudsman. It was

likely that factors connected with infection risk would put pressure on the normal multi-agency process after death.

60. It is clear from this guidance from my predecessor, my own experience working in the criminal justice system, and the discussions I had during my tour of all coroner areas in England and Wales from January 2022 to March 2023, that the first impacts of the pandemic on the coroner service were as follows:

a) Many inquests had to be adjourned, particularly complex cases and those requiring juries, although some urgent hearings did go ahead. In some coroner areas, partially remote inquests were held in suitable cases with witnesses and participants attending online, but many coroner areas did not have the necessary IT systems to enable that to happen initially (in general, IT capabilities improved as the pandemic progressed because local authorities funded better provision). Adjournments and inability to list new inquests meant backlogs began to build.
b) Another consequence for areas using older IT systems was that when the pandemic first struck, many areas did not have home-working capability. Although coroners, coroners' officers and staff were classed as key workers, those who were vulnerable, or had vulnerable family members, could not attend their workplaces. Their inability to work from home reduced the capacity of coroner areas to deal with death referrals and the early stages of death investigations.
c) Absence levels were higher than usual amongst coroners, coroners' officers and staff because of illness, caring responsibilities, bereavement, the need to self-isolate etc. This created or worsened capacity problems throughout the system and made it more likely that investigations would be delayed.
d) Higher numbers of excess deaths put pressure on the death management system. In most parts of the country, mortuary storage capacity was anticipated to be seriously insufficient (affecting all deceased persons, not just those whose deaths were under the investigation of the coroner), and in some parts of the country that risk materialised. In addition, there were delays in obtaining MCCDs because of the pressure on doctors; and there were insufficient registrar appointments, funeral service times and burial and cremation slots to meet the increase in demand. This meant that body disposal was delayed, exacerbating

mortuary capacity problems. Coroners in each area worked as part of their Local Resilience Forum (which brings together all relevant local individuals and organisations including the police, ambulance service, GPs, hospitals, local authorities etc) to manage the pressures within the system, including setting up temporary mortuaries to mitigate the risk that existing provision would become overwhelmed, and working to ensure that bodies were released promptly. The additional work that coroners had to do to safeguard against the system collapsing affected their capacity to progress investigations and conduct inquests.

e) It was not pragmatic or proportionate for coroners to make the same decisions in the early days of the pandemic as they would have made in normal times, so they had to adapt their methods of investigation. For example, as an alternative to an invasive post-mortem examination, coroners sometimes arranged a COVID-19 test and an external examination of the body, as that assisted them to determine the cause of death without increasing capacity pressures or health risks for pathologists.

f) Coroners, coroners' officers and staff were under severe pressure to manage the impacts of the pandemic and to adapt as the situation rapidly developed. Working excessive hours without leave, under stress and often in isolation, impacted on their welfare.

61. As the pandemic developed and restrictions were eased, non-urgent in-person hearings resumed with social distancing measures in place. As coroner areas are locally funded and resourced, there is a wide variation in their accommodation. Some coroner areas had spacious courtrooms that could accommodate complex and jury inquests (where a group of 7 to 11 jurors and/or participants in the hearing could all remain far enough apart). Many areas, however, did not have the necessary facilities, so complex and jury cases had to wait in those areas until larger premises could either be obtained or social distancing requirements were eased.

62. Coroners' ways of working were also affected by indirect pressures caused by the pandemic. For example. when dealing with medical professionals (including pathologists), coroners had to recognise the primary clinical commitments that affected those clinicians' ability to participate in coronial processes. This meant

considering: avoiding or deferring requests for lengthy reports/statements; accommodating clinical commitments if calling clinicians as witnesses; admitting written evidence under rule 23 of The Coroners (Inquests) Rules 2013; and granting extensions to deadlines for evidence and responses to Prevention of Future Deaths Reports.

63. My predecessor actively supported coroners from the early stages of the pandemic onwards. He set up a Covid Cadre, which was a group of coroners from around England and Wales (in both urban and rural areas) who met regularly with the Chief Coroner and the two Deputy Chief Coroners (initially at least twice weekly) to discuss the impacts of the pandemic, identify trends, share learning and offer support. Brief minutes were kept of the meetings by a member of the Chief Coroner's office.

64. Whilst my office maintained a productive working relationship with officials responsible for death management in the Ministry of Justice throughout the pandemic, including keeping them aware, as appropriate, of any developing issues for the service, the coroner service received no additional information from the Government about the pandemic's progress than was available to the public from sources such as news broadcasts. The Covid Cadre therefore played an important role in building a national picture for coroners of how the pandemic was developing and impacting on the service. As waves of the pandemic started in different areas, information from the Covid Cadre enabled forward-planning by coroners in areas not yet affected. For example, information from a London coroner about the limited extent of the temporary mortuary facilities that could be provided by the Government, enabled those in other areas to pre-empt the problem and find solutions, including Birmingham arranging to use Aston Villa football ground as a temporary mortuary if necessary, and Milton Keynes hiring the local ice rink. It was clear from my predecessor's discussions with the Covid Cadre that coroners were making considerable efforts to plan for excess deaths, and he was able to disseminate their innovative ideas to coroners throughout the country.

65. The Covid Cadre was also an important forum for coroners to raise welfare concerns, giving my predecessor and me an insight into how coroners were being affected by the pandemic, which enabled us to provide wider support. The group was so successful, that I formalised it by appointing 5 regional coroners in September

2021 and giving them a wide remit in terms of information sharing and welfare support.

66. As the pandemic progressed, imaginative solutions were found to enable some jury inquests to proceed. For example, 'Pitman's Parliament' in Durham (which is a huge historic debating chamber used by miners) was adapted for use by coroners for inquests, as it was large enough to seat jurors and participants 2 metres apart. Photographs of the hall depicting the social distancing requirements (with blank pieces of paper representing the jurors) are exhibited to this statement as CC/11 – [INQ000477334]. These photographs make it easy to visualise the scale of the challenge posed by jury hearings during the pandemic.

67. In July 2021 (in England) and August 2021 (in Wales), social-distancing restrictions were lifted, and the coroner service was able to operate more normally. However, there were continuing impacts on the service. The biggest problem was delay. Before the pandemic, many coroner areas were already suffering the impacts of chronic under-funding. The demands placed on the service between March 2020 and July 2021 and the need to adjourn inquests led to a build-up of work.

68. Published statistics present a complex picture, as there were many factors affecting service delivery. For example, there was a reduction in the numbers of deaths reported to coroners in 2020 (there were 205,438 reported deaths, down from 210,900 in 2019) and in 2021 (there were 195,200 reported deaths, down from 205,438 in 2020). Possible reasons for this reduction include that: the medical examiner system was successful in diverting some cases away from coroners; some unnatural causes of death dramatically reduced because of lockdowns, including road traffic accidents (down 22% in 2020) and unlawful killings (down 55% in 2020); most deaths from COVID-19 were natural deaths, and the easements introduced in the CA 2020 meant that MCCDs could often be signed by doctors for natural deaths without the need for a report to the coroner.

69. That trend reversed in 2022, however, when reported deaths increased to 208,400. The increase seems to have been the result of a variety of factors, including the following:

a) Changes in medical practice (that were made in response to the pandemic - such as the increase in telephone consultations with General Practitioners - but remained in place after restrictions were lifted) meant that more people were dying from natural causes without having recently been seen by a medical practitioner. When most of the easements that had been introduced by the CA 2020 expired in March 2022, many more natural deaths had to be reported to coroners because there was no medical practitioner who could sign an MCCD;
b) Families were more likely to have concerns about the medical treatment their deceased loved ones received, leading to reports to coroners about deaths that would usually have been considered natural. This may have occurred because families were restricted from visiting loved ones in health and care settings, so they did not witness any gradual deterioration in their loved ones' health or build up relationships with doctors/carers. The enormous pressure the pandemic put on health and care systems also meant resources were stretched, compromising standards of care in some cases.

70. In parallel with the 2022 rise in reported deaths, the discussions I held with coroners and coroners' officers during my welfare tour of all coroner areas in England and Wales suggest that cases have become more complex. There are many reasons for this change, including the following:

a) The past decade has witnessed increasing technical, organisational, procedural and legal complexity in many aspects of modern life. There are, concomitantly, greater expectations on the coroner system to provide explanations about deaths. This means that coroners more often deal with factually complicated investigations that generate significantly greater volumes of material than would formerly have been expected.
b) In contentious inquests, interested persons have become more inclined to apply pressure on coroners to expand the scope of their investigations. In particular, the limited availability of state funding for bereaved families except where it is required under the European Convention on Human Rights has fueled persistent demands for coroners to decide that Article 2 is engaged.
c) The increased professionalisation of the coroner service has subjected coroners to more stringent processes and demands. This has been an incremental

process, ranging from tackling inappropriate practices that used to save coroners time (for example, Chief Coroner Guidance No. 8 issued in 2013 ended the use of pre-signed forms), to embedding best practice (for example in relation to the provision of disclosure, as explained in Guidance No. 44 issued in September 2022).

d) The introduction of the medical examiner system has meant that complex cases where reportable factors might previously have been missed are now being identified and reported to coroners for investigation.

71. The rise in the number of reported deaths in 2022, the growth in case complexity, and the work coroners have had to do to try to tackle pandemic backlogs, have meant that coroners' workloads have increased.

72. My predecessor anticipated this problem at the start of the pandemic, so he and the Lord Chancellor agreed that in principle they would both be willing to consent to the appointment of assistant coroners by local authorities without open competition, to deal with urgent workload pressures. In Wales, coroners were also encouraged to use existing provisions that already enabled cross-deployment between coroner areas within the principality. The extent to which the complement of coroners could be increased was however limited by the pool of people who had sufficient skills and experience for appointment. Increasing resourcing of any kind was also dependent on local authorities agreeing to provide additional funding at a time of increased economic pressure.

73. My understanding from speaking to the two Deputy Chief Coroners – who were in post throughout the pandemic and supported my predecessor with appointments - is that in practice no new assistant coroners were appointed under the emergency scheme (although a small number of existing assistant coroners were appointed as assistant coroners in other areas nearby, to improve resilience). At the peak of the lockdown, coroners were under intense pressure and did not have time to complete the administration needed to arrange the appointment of new coroners (including agreeing with the local authority that an appointment should be made, finding a candidate and training them). The only requests to use the emergency provisions that the Deputy Chief Coroners can recall, were made after the lifting of restrictions,

when coroners were trying to tackle their backlogs. Those requests were refused because the initial emergency had passed and there was time to run an open competition.

74. The combination of increased workloads and insufficient resourcing has adversely affected the speed with which cases can be progressed. In 2021, statistics published by the Ministry of Justice indicated that the time taken to process an inquest had increased by 4 weeks to 31 weeks. In 2022, the time taken to process an inquest decreased to 30 weeks, but was still higher than the pre-pandemic baseline.

75. Each year, I publish information about the number of cases that have been in the system for more than 12 months, which I collect as a 'snapshot' on a particular day in April. My figures show that in 2019 there were 2,278 cases that had not been dealt with within 12 months. The figures for 2020 are incomplete, but in 2021 there were 5013 cases, and in 2022 there were 4812 cases. The figures for 2023 will be published in my next annual report, but sadly the total is substantially higher than last year. These figures indicate that backlogs remain high and that some Interested Persons have been experiencing delays in inquests reaching a conclusion.

76. As I have explained, the reasons for delays are complex. In addition to the factors I have already mentioned, there are other reasons why cases are sometimes subject to delay, including inefficient practices by coroners (which I have been working to reduce), delays where the coroner must wait for charging decisions by the Crown Prosecution Service, the outcome of complex specialist investigations by organisations such as the Health and Safety Executive or the Air Accident Investigation Branch, or post-mortem examination reports (which are often delayed because of the national shortage of pathologists, especially where specialist evidence is needed). However, the pandemic has undoubtedly had a significant impact on the timeliness of investigations.

Deaths reported to the Health and Safety Executive (HSE)

77. Some deaths of workers from COVID-19 must be reported by the responsible person (usually the employer) to HSE. The requirement to notify HSE arises where there has been occupational exposure to COVID-19 which has caused a worker's death.

78. There is also a separate obligation on registrars and medical practitioners to report deaths to coroners that are suspected to have been caused by occupational exposure to COVID-19. The NODR Regulations state that coroners have to be notified of deaths suspected to be due to an injury or disease attributable to any employment held by the deceased person during their lifetime. There is a similar obligation for registrars to notify coroners of deaths that appear to have been due to industrial disease or industrial poisoning. There is also a general obligation on medical practitioners and registrars to report deaths that are suspected to be unnatural, which would include deaths where there is a concern that human failure was a contributing factor. This would cover cases where, for example, a worker contracted COVID-19 at work because they did not have appropriate access to PPE, or because appropriate infection control measures were not implemented in their workplace.

79. On 20 May 2020, my predecessor met officials at HSE to discuss the pandemic. At that meeting, it was noted that 80 COVID-19 deaths had been reported to HSE, but their figures were much lower than those held by DHSC in relation to the deaths of health and care workers. HSE were concerned about under-reporting of workers' deaths, although they were planning to change their guidance to try to combat this. The note of that meeting is exhibited to this statement as CC/09 – [INQ000477342].

80. If deaths of this type continued to be under-reported to HSE after HSE changed its guidance, it is likely that coroners received fewer notifications of workers' deaths from COVID-19 than they otherwise would have done. Not realising that there was an occupational element to some COVID-19 deaths, registrars and medical practitioners might have certified them as natural. If HSE had been notified by the employer that a death had an occupational connection, HSE might have alerted the coroner, or a family member might have mentioned the HSE notification to the registrar who should then have made a report.

81. It is questionable, however, whether any under-reporting to HSE substantially affected the number of COVID-19-related inquests. As I mentioned above, the Health Service and Social Care Workers (Scrutiny of Coronavirus-related Deaths) Directions 2020 meant that from July 2020 medical examiners conducted scrutiny into the deaths of health and care workers. Those directions led to the referral to coroners of some deaths that had originally been missed. Even when deaths were referred to coroners, the reports may not have led to inquests. HSE can investigate concerns about infection-control practices even if there is no way to establish where a worker contracted COVID-19. However, for a coroner to investigate, there must be evidence of causation. In other words, the coroner has to be able to establish that it is more likely than not that the person who died contracted COVID-19 at work, as opposed to somewhere else (as if they contracted the virus elsewhere and received appropriate medical treatment, their death would be natural and would fall outside the coroner's jurisdiction). Since COVID-19 was rife in the community throughout the pandemic, it was very difficult for coroners to be able to establish how a worker fell ill. Deaths reported to coroners might therefore have ended with the coroner deciding that the duty to investigate was not engaged.

82. One potential impact on the coroner service of deaths being reported to HSE was that the need for a jury inquest might have been triggered, as section 7 of the 2009 Act provides that if a coroner has reason to suspect that a death was caused by 'a notifiable accident, poisoning or disease' any inquest into the death must be held with a jury. However, section 7(5) was inserted into the 2009 Act by the CA 2020 in March 2020, which provides that COVID-19 is not a notifiable disease for the purposes of section 7 (in other words, juries are not mandatory in COVID-19 cases). When the CA 2020 expired on 24 March 2022, the Judicial Review and Courts Act 2022 provided for the jury easement to remain in place until 27 June 2024. It will therefore expire soon, unless it is extended for up to two years by the Secretary of State for Justice.

83. But for the jury easement, the fact that a COVID-19 death was reportable to HSE would have triggered the need for a jury, which would have added to the backlog of jury cases that were created by pandemic restrictions (see also paragraph 40 of this statement).

The impact of excess deaths on the accuracy of registration and/or recorded cause of deaths

84. As I mentioned above, in the exceptional circumstances of the pandemic it was sometimes not pragmatic or proportionate for coroners to investigate in the same way as they would have done in normal times. However, that did not make coroners' conclusions inaccurate. As the case of *Coroner for the Birmingham Inquests (1974) v Hambleton and Others [2018] EWCA Civ. 2081* made clear, it is for the coroner to decide 'what is necessary, desirable and proportionate by way of investigation to enable the statutory functions to be discharged', and the coroner has a wide discretion. The coroner's obligation is to make sufficient, not exhaustive, inquiry.

85. The level of certainty that a coroner needs to reach is only 'the balance of probabilities', in other words that something is more likely than not. If a coroner adopted a pragmatic approach to an investigation during the pandemic, the coroner would still have to have been satisfied on the balance of probabilities that their findings, determinations and conclusions - including cause of death - were correct. A judicial decision made by a coroner is correct unless it is successfully challenged in the courts.

Prevention of future deaths reports

86. 40% of all deaths are reported to coroners, of which 6% lead to an inquest being opened and 0.1% result in a Prevention of Future Deaths Report. This means that there are approximately 500 reports written each year, (Qingyang & Richards, 2023 Medico-Legal Journal).

87. Between 1 March 2020 and 28 June 2022, 865 reports were published by the Chief Coroner, 27 of which related to COVID-19. The relevant reports are exhibited to this statement as follows:

- CC/11 – [INQ000477324] – Sarah Dunn;
- CC/12 – [INQ000477325] – Laura Medcalf;

- CC/13 – [INQ000477326] – John Murphy;
- CC/14 – [INQ000477327] – Richard Scott-Powell;
- CC/15 – [INQ000477328] – Alan Hodgson;
- CC/16 – [INQ000477329] - Sameena Javed;
- CC/17 – [INQ000477330] - Hurrun Maksur;
- CC/18 – [INQ000477331] – Edward Cockburn;
- CC/19 – [INQ000477332] – Alan Hunter;
- CC/20 – [INQ000477333] – Nicholas Spooner;
- CC/21 – [INQ000477307] – Lynn Hadley;
- CC/22 – [INQ000477308] – Mark Holden;
- CC/23 – [INQ000477309] – Harold Blackshaw;
- CC/24 – [INQ000477310] – Hazel Wiltshire;
- CC/25 – [INQ000477311] – Steve Cooke;
- CC/26 – [INQ000477312] – Geoffrey Hill;
- CC/27 – [INQ000477313] – Chimezie Daniels;
- CC/28 – [INQ000477314] - Khairul Rahman;
- CC/29 – [INQ000477315] – Ian Hall;
- CC/30 – [INQ000477316] – Brian Mottram;
- CC/31 – [INQ000477317] – Clive Rivers;
- CC/32 – [INQ000477318] – Alfred Jones;
- CC/33 – [INQ000477319] – Derek Russell;
- CC/34 – [INQ000477320] – Brian Button;
- CC/35 – [INQ000477321] – Shyama Rampadaruth;
- CC/36 – [INQ000477322] – Leslie Harris;
- CC/37 – [INQ000477323] – Anthony Slack.

88. Specific infection control concerns raised by coroners in the reports are as follows:

a) A person contracted COVID-19 from hospital. The beds in the ward were not socially distanced.

b) A person contracted COVID-19 in hospital having been put in a bay with patients who had been exposed to the virus because of the Trust's interpretation of PHE guidance. At the time of the report, the Trust's policy had been changed, but the PHE guidance had not been amended.

c) A person died of COVID-19 having contracted it at a care home. Processes within the care home, and knowledge of PPE requirements, were inadequate.

89. Six of the other Prevention of Future Deaths Reports exhibited to this statement mention that the deceased person contracted COVID-19 in a hospital or care home, but those reports do not raise concerns about infection control practices.

90. Other concerns raised in the reports relating to the pandemic include the following:

a) A person was incorrectly assumed to have COVID-19 because a bias in clinicians' thinking as a result of the pandemic meant that an alternative diagnosis was not considered.
b) Ambulance delays caused by vehicle and staff shortages, and the delays in clearing ambulances from Accident and Emergency departments, meant paramedics were being delayed in attending Category 2 calls.
c) A person was wrongly diagnosed following difficulties in communication contributed to by the need for PPE.
d) A person who had COVID-19 symptoms was to be given oxygen therapy from a cylinder whilst at home. The paramedic turned on the oxygen cylinder, which sparked and set the house alight.
e) The increased risk of blood clots in patients with COVID-19 was not recognised by NICE guidance.
f) Long delays in responding to call bells meant a patient did not continue to wait for assistance with toileting, and fell. Patients with COVID-19 had higher dependency, so staffing levels were too low.
g) A person suffering from COVID-19 was on a continuous positive airway pressure (CPAP) machine. An alarm sounded to alert staff to a cessation of oxygen, but it was the same sound as the alarm for a small leak in the mask. It was therefore difficult for staff to establish the cause of the patient's low oxygen saturation levels. Four other CPAP alarms were also sounding on the ward at the same time and the ward was under-staffed.
h) Medical observations of a patient in custody who died from COVID-19 had not complied with NEWS2 requirements (which is a system for scoring health

measurements to determine a patient's degree of illness and prompt critical care intervention) and there was no alternative system for prison healthcare settings.

i) Telephone consultations with General Practitioners led to missed diagnosis.

j) In one area, it was unclear what system General Practitioners were using to identify patients who were vulnerable to COVID-19.

k) There was a chronic shortage of falls alarms, which had been exacerbated by the pandemic.

l) COVID-19 infection precautions meant a frail 86-year-old patient's renal dialysis had to be delayed, so she was left on a hard chair in a hospital waiting room for around 6 hours.

91. No inequality-related issues in relation to the way the healthcare system dealt with deaths were mentioned in Prevention of Future Death Reports, nor were any brought to my attention, or to the attention of my predecessor, between 1 March 2020 and 28 June 2022.

The impact of the pandemic in Scotland and Northern Ireland

92. I do not have sufficient knowledge of the death investigation systems in Northern Ireland or Scotland to be able to comment on how those systems functioned during the pandemic in comparison with the coroner service in England and Wales.

Conclusion

93. I can confirm that I do not have any recommendations to make in relation to healthcare systems which may enable a more efficient and effective response by the coroner service in the event of a future pandemic. In my view, the key change that is needed to improve the resilience of the coroner service and enable it to meet any future challenges is to correct the chronic under-funding and under-resourcing of the service.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

Personal Data

Dated: 23 May 2024